

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

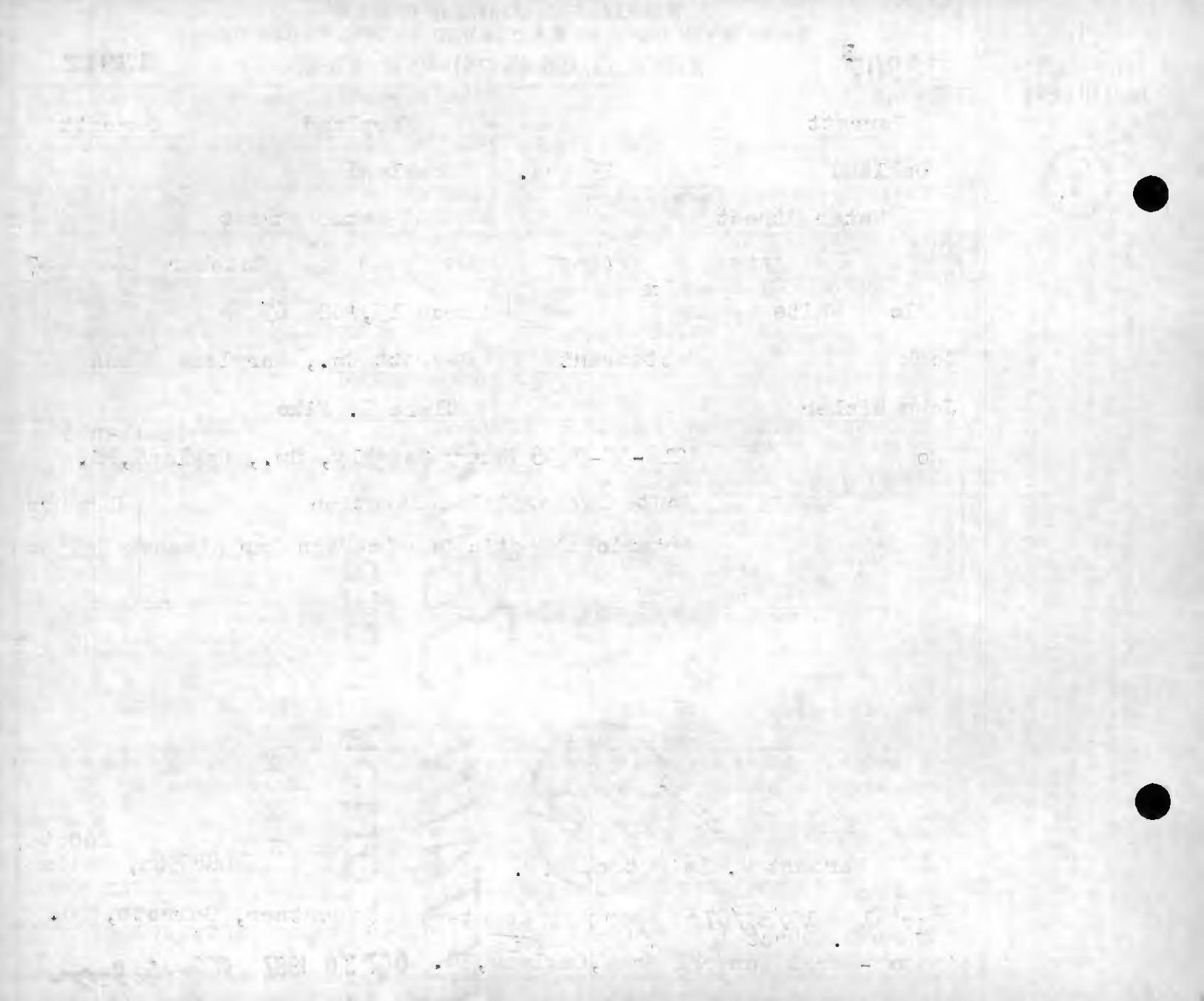
13912

FOR STATE  
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13907		MEDICAL EXAMINER'S CERTIFICATE OF DEATH								
1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) d. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>25 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		d. STREET ADDRESS <b>205 Water Street</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>205 Water Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>ELMINA</b>		First	Middle	Last	4. DATE OF DEATH <b>October 26 1967</b>		Month	Day	Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, '02</b>		9. AGE (In years last birthday) <b>65 yrs.</b>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Garrett Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John Sisler</b>				14. MOTHER'S MAIDEN NAME <b>Clara E. Fike</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>218-30-0636</b>		17. INFORMANT <b>Harry Beeghly, Sr., Oakland, Md.</b>		Address (Husband) <b>Oakland, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> INTERVAL BETWEEN DUE TO <b>4201</b> ONSET AND DEATH 2 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> Unknown DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
MEDICAL CERTIFICATION		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) <b>Oakland</b> (County) <b>Garrett</b> (State) <b>Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Herbert H. Leighton</i> M.D. EXAMINER'S NAME (Type) <b>Herbert H. Leighton, M.D.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/29/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Gortner Cemetery</b>		23d. LOCATION (City or Town) <b>Gortner, Garrett, Md.</b> (County) <b>Garrett</b> (State) <b>Md.</b>				
24. FUNERAL DIRECTOR <b>Durst</b>		ADDRESS <b>Leighton-Durst Funeral Home, Oakland, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 30 1967</b>		25b. REGISTRAR'S SIGNATURE <i>John O. Durst</i>				



**M**  
FOR STATE  
HEALTH DEPT.

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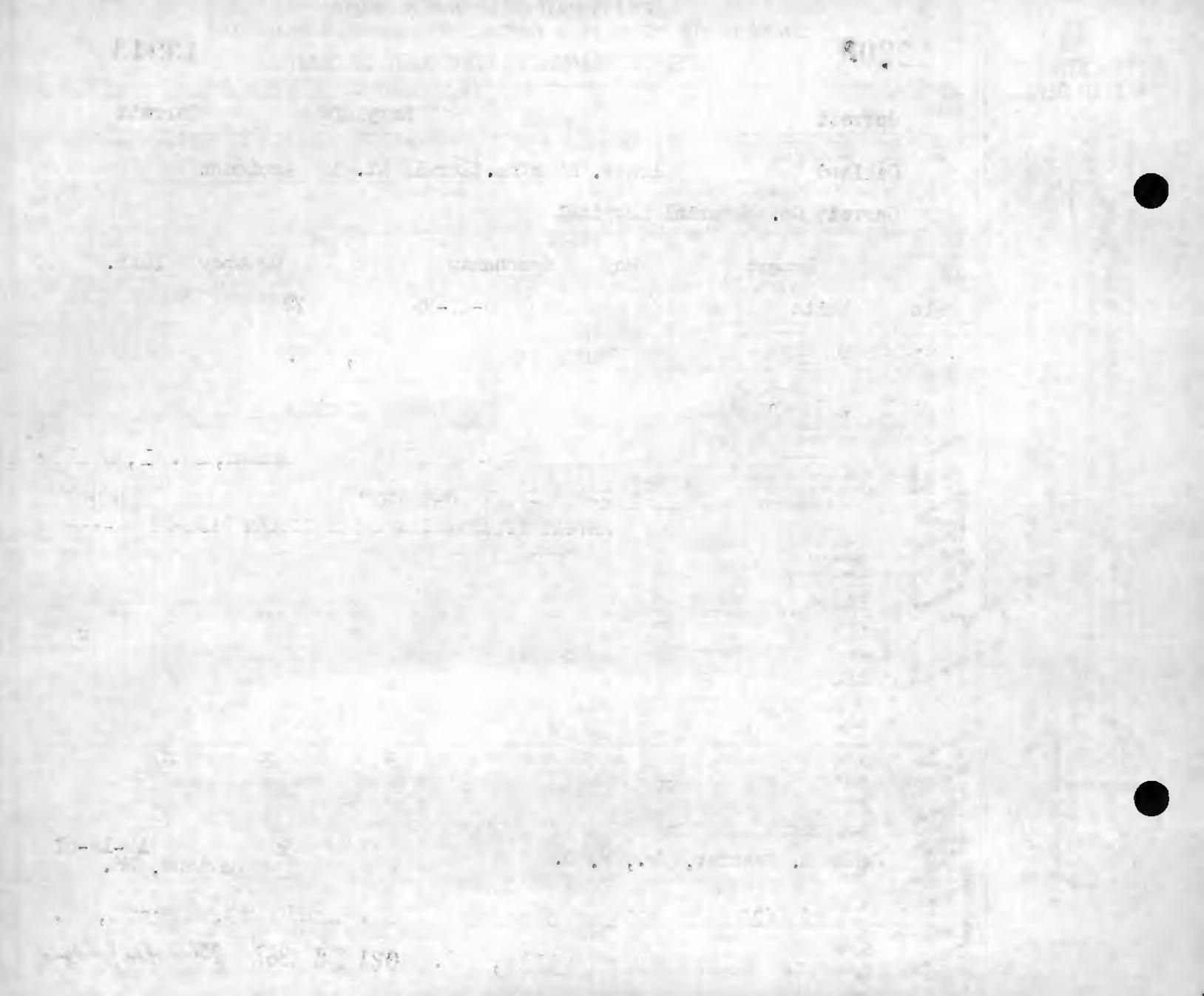
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13913

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>12hrs. 45 mins.</b> (Rural) Rt. 1 Accident	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Memorial Hospital</b>		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Ernest</b>		First <b>Ray</b>	Middle <b>Brenneman</b>
4. DATE OF DEATH <b>October 18th, 1967</b>	Month	Doy	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <b>6-27-95</b>		9. AGE (In years last birthday) <b>72</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Bittinger, Md.</b>
13. FATHER'S NAME <b>Samuel D. Brenneman</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Jenkins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. - - -	17. INFORMANT <b>Mrs. Amelia Brenneman, Rt. 1, Accident</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)		SUBARACHNOID HEMORRHAGE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
		INTERVAL BETWEEN ONSET AND DEATH HOURS ----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)
		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>10-18-67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/22/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Glade Cemetery</b>
23d. LOCATION (City or Town) (County) (State) <b>Garrett, Md.</b>		23e. ACCIDENT, GARRETT, MD.	
24. FUNERAL DIRECTOR <i>Rich Newman</i>		25a. REC'D BY REGISTRAR <b>Charles J. Judge</b>	
		25b. REGISTRAR'S SIGNATURE <b>OCT 26 1967</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13908

CERTIFICATE OF DEATH

13914

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland, Md.</b> c. LENGTH OF STAY IN 1b <b>6 days 12Hrs</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sang Run</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Garrett Co. Memorial Hospital</b>		d. STREET ADDRESS <b>Box # 104</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>First Jesse Middle Frank Last Browning</b>		4. DATE OF DEATH Month <b>10</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-17-83</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Sang Run, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Nathen Casteel Browning</b>		14. MOTHER'S MAIDEN NAME <b>Anna E. Fazenbaker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-14-6575</b>	
17. INFORMANT <b>Son</b>		Address <b>Oakland, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Myocardial insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48</b>	
DUE TO <b>(b) Myocardial insufficiency</b>			
DUE TO <b>(c) arteriosclerotic CV Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) <b>Oakland, Md.</b> (County) <b>Garrett Co.</b> (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1967</b> to <b>10-23-67</b> , 1967, that (I) (we) last saw the deceased alive on <b>10-22-67</b> 1967, and that death occurred at <b>7:25AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>B. L. Grant</b>		22b. DATE SIGNED <b>10/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. B. L. Grant</b>		22d. ADDRESS <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/26/67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Hoyes Cemetery</b>		23d. LOCATION (City or Town) <b>Garrett Co.</b> (County) <b>Maryland</b> (State)	
24. FUNERAL DIRECTOR <b>Gerald N. Minnich</b>		25a. REC'D BY REGISTRAR <b>OCT 30 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

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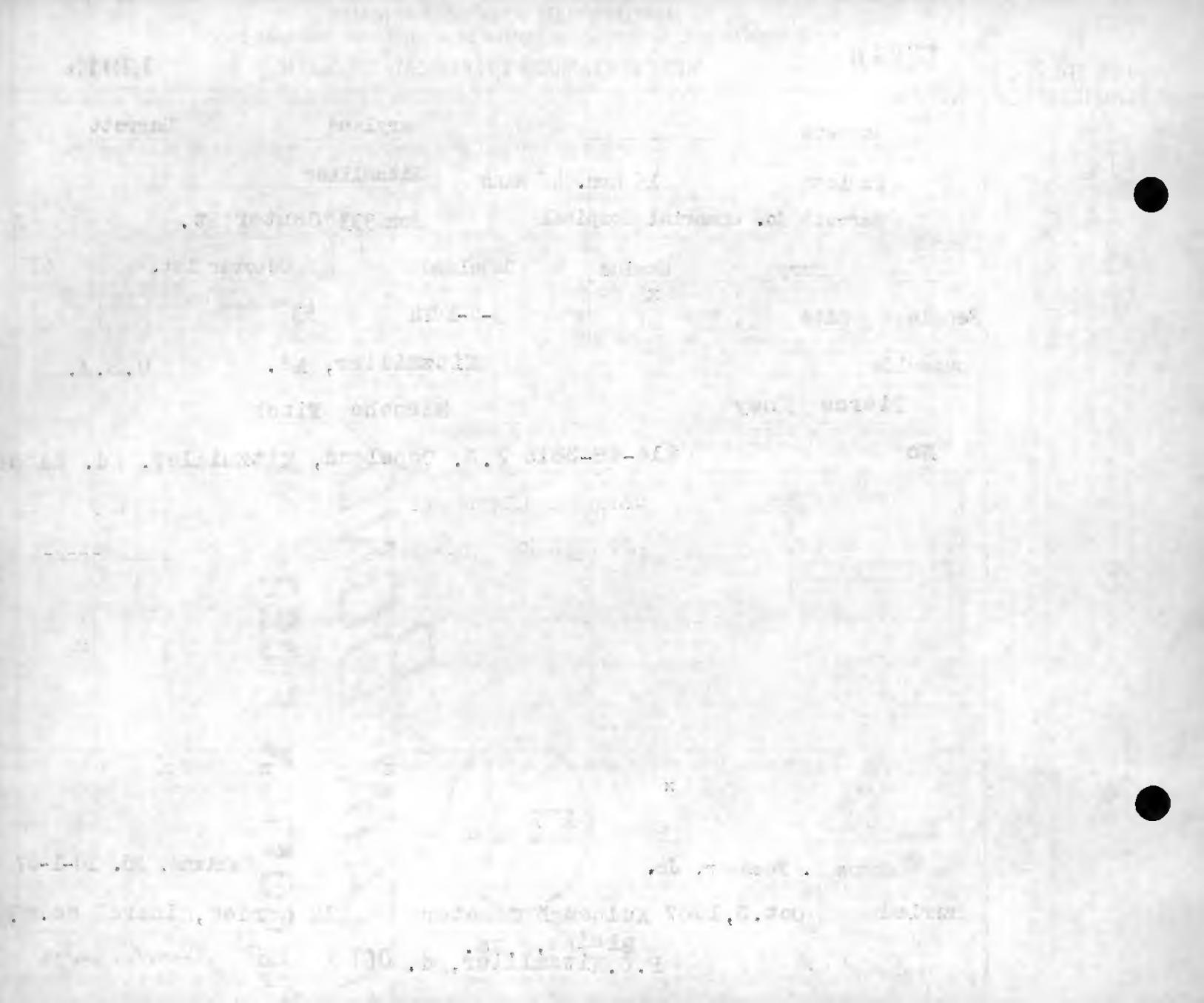
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13970

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13915

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>15 hrs. 45 mins</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Memorial Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kitzmiller</b>	
d. STREET ADDRESS <b>Box 333 *Center St.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First <b>Maxine</b>	Middle <b>Copeland</b>
3. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF DEATH <b>October 1st.</b>		9. DATE OF BIRTH <b>3-9-1914</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Kitzmiller, Md.</b>	
13. FATHER'S NAME <b>Pierce Hoey</b>		14. MOTHER'S MAIDEN NAME <b>Blanche Finch</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-48-3315</b>	
17. INFORMANT <b>J.R. Copeland, Kitzmiller, Md. 2153</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>223 X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 / 7 days</b>	
DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		CEREBRAL HEMORRHAGE BRAIN TUMOR (MENINGIOMA)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Oakland, Mi.</b>		(County) <b>10-1-67</b>	
(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <b>James H. Feaster, Jr.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 3, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Kalbaugh Cemetery</b>
23d. LOCATION (City or Town) <b>Elk Garden, Mineral Co. W.V.</b>		(County) <b>W.V.</b>	
(State)			
24. FUNERAL DIRECTOR <b>Amy Mildred Sheppard</b>		25a. REG'D BY REGISTRAR <b>Blaine, W. Va.</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
P.O. Kitzmiller, Md.		DATE <b>OCT 3 1967</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13911

13916

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
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1. PLACE OF DEATH a. COUNTY <b>Garrison</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Thomas, W. Va.</b>		d. STREET ADDRESS <b>Rt. 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Claud</b>		First <b>(n)</b> Middle		4. DATE OF DEATH <b>October 3 1967</b>		Month Doy Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/4/92</b>		9. AGE (In years lost birthday) <b>75 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Doy <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Westernport, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Corbin, Thomas (n)</b>		14. MOTHER'S MAIDEN NAME <b>Weese, Betty (n)</b>				Address <b>Elmwood Corbin Rt. 1, Thomas, W. Va.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>232-09-0469</b>		17. INFORMANT <b>Elmwood Corbin</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>177X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of prostate with metastases</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> , 19 <b>67</b> , to <b>Oct. 3</b> , 19 <b>67</b> , that (I) (he) last saw the deceased alive on <b>10-3-67</b> , 19 <b>67</b> , and that death occurred at <b>2:35 PM</b> from causes and on the date stated above.	
22a. SIGNATURE <b>James H. Feaster, Jr.</b>		20c. TIME OF INJURY Month, Day, Year Hour: o.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) <b>Oakland</b>	(County) <b>Garrett</b>
22c. PHYSICIAN'S NAME (Type) <b>Dr. James H. Feaster, Jr.</b>		22d. ADDRESS <b>Oakland, Maryland</b>				22b. DATE SIGNED <b>10-3-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 5, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Garrett Co. Mem. Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Oakland, Garrett, Md.</b>	
24. FUNERAL DIRECTOR <b>John Dunes</b>		ADDRESS <b>Thomas, W. Va.</b>		25a. REC'D BY REGISTRAR <b>ACT 6</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13917

FOR STATE  
HEALTH DEPT.

3912  
4  
Page 3  
PM3  
12/14/67

This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 5, which may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO ATTORNEY:

This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with item 5, which may be retained for your files.

1 PLACE OF DEATH a COUNTY <b>Garrett</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c LENGTH OF STAY IN lb Minutes <b>Minutes</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Friendsville</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>(DOA) Garrett Co. Memorial Hospital</b>			d STREET ADDRESS		
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (First, Middle, Last) <b>Alice Pearl Fair</b>		4 DATE OF DEATH <b>October 9th, 1967</b>			
5 SEX <b>Female</b>		6 COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		9. DATE OF BIRTH <b>7-14-1910</b>		10. AGE (In years lost birthday) <b>57 yrs.</b>	
11. BIRTHPLACE (State or foreign country) <b>Friendsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>None</b>			
13. FATHER'S NAME <b>Ellis Artice</b>		14. MOTHER'S MAIDEN NAME <b>Daisy Selby</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>016-70-7816</b>		17. INFORMANT <b>Dynamic Fair, Friendsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> DUE TO Conditions, injury, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Coronary arteriosclerosis</b> Years DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d INJURY OCCURRED While <input type="checkbox"/> Not While of work <input type="checkbox"/> at work <input type="checkbox"/>			
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20e PLACE OF INJURY (Home, farm, factory, street, off a bldg. etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i> MD					
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>10/12/67</b>		23c NAME OF CEMETERY OR CREMATORIAL <b>Friendsville Cemetery</b>	
24 FUNERAL DIRECTOR <b>Frank Newman</b>		ADDRESS <b>Granville, Md.</b>		25a REC'D BY REGISTRAR <b>Charles Judge</b>	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
22. DATE SIGNED <b>10-9-67</b>					
Address (Street, city, town, or county) <b>Oakland, Md.</b>					
23d LOCATION (City or Town) (County) (State)					
25c REC'D BY REGISTRAR'S SIGNATURE					
DATE <b>OCT 13 1967</b>					



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

## FOR STATE HEALTH DEP

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**NO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages 1 and 2 with Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 May 1911. *Yule lines.*

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1/67

## **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13914

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Garrett		a. STATE Maryland	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CITY OF BOSTON, MASS.		c LENGTH OF STAY IN 1b 1 YEAR	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOSTON, MASS.	
3. NAME OF DECEASED (Type or print) Maria Magdalena (Lorenz) (Last)		4. DATE OF DEATH Month October 3, 1967	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED WIDOWED		8. NEVER MARRIED DIVORCED	
9. DATE OF BIRTH Dec. 20, 1892		10. AGE (In years, months, birthday) 74 yrs.	
11. BIRTHPLACE (State or foreign country) Garrett County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Weber		14. MOTHER'S MAIDEN NAME Henrietta Koll	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 123-45-6789	
17. INFORMANT John J. Weber		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 Arteriosclerosis, Generalized	
DUE TO (b) Arteriosclerosis, Generalized		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Fraster, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James H. Fraster, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 10.3.67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) OAKLAND, MD		23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 1967	
23b. DATE THEREOF 7/4/67		23c. NAME OF CEMETERY OR CREMATORIAL Dr. John Lubin, Jr.	
24. FUNERAL DIRECTOR Burk Newman		23d. LOCATION (City or Town) (County) (State)	
ADDRESS Charlottesville, VA		25a. REC'D BY REGISTRAR DATE OCT 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13919

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Oakland		c. LENGTH OF STAY IN 16 25 yrs		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Oakland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #2		d. STREET ADDRESS Route #2				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First MARY	Middle ANN	4. DATE OF DEATH October 31,	Month 19	Day 67	Year						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1890	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State or foreign country) Garrett Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Thomas Crowe				14. MOTHER'S MAIDEN NAME Martha Aronhalt							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 218-50-0515		17. INFORMANT Richard Hesse, Rt 2, Oakland, Md.		Address (Son)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO Arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Oakland		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to 3 Oct, 1967, that (I) (we) last saw the deceased alive on 25 Oct 1967, and that death occurred at 12:30 M, from causes and on the date stated above.											
22a. SIGNATURE A. E. Mance		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov 67			
22c. PHYSICIAN'S NAME (Type) Andrew E. Mance, M.D.		22d. ADDRESS Oakland, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/3/67		23c. NAME OF CEMETERY OR CREMATORIAL Egleton Cemetery		23d. LOCATION (City or Town) Egleton, Preston, W. Va.		(County)		(State)	
24. FUNERAL DIRECTOR John O. Durst		ADDRESS				25a. REC'D. BY REGISTRAR NOV 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			
Loighton-Durst Funeral Home, Oakland, Md.											



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13920

13915

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician  
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN b <b>23 days-13 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Ralph</b>	Middle <b>Keller</b>	Last <b>Jenkins</b>
4. DATE OF DEATH Month <b>October</b>	Day <b>26, 19</b>	Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>1880</b>	9. AGE (in years lost birthday) yrs <b>87</b>	F. UNDER 1 YEAR Months <b>0</b>	I. UNDER 24 HRS. Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William</b>	14. MOTHER'S MAIDEN NAME <b>Jenkins</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Cerebralized Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>p.m.</b> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Grantsville, Garrett, Maryland</b>	20f. (City or town) <b>Grantsville</b> (County) <b>Garrett</b> (State) <b>Maryland</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1966</b> to <b>Oct 1967</b> , that (I) (we) last saw the deceased alive on <b>25 Oct 1967</b> , and that death occurred on <b>12:05 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>B. L. Grant</i>	22b. DATE SIGNED <b>26 Oct 67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. B. L. Grant</b>	22d. ADDRESS <b>Oakland, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/28/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>J.C. of C. Cem. - th Cem.</b>	23d. LOCATION (City or Town) <b>Grantsville, Garrett, Maryland</b> (County) <b>Garrett</b> (State) <b>Maryland</b>
24. FUNERAL DIRECTOR <i>Kathy Newman</i>	ADDRESS <b>Grantsville, Maryland</b>	25a. RECD BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15 (4) 20 M 1/60	DATE <b>OCT 30 1967</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13921

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper; Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		a. STATE Maryland		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Kitzmiller		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Kitzmiller		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Center Street		First		Last		4. DATE OF DEATH		Month	
3. NAME OF DECEASED (Type or print)		Delphia		Middle		5. SEX		Oct. 26		Day	
Female		White		M.		6. COLOR OR RACE		9. AGE (In years last birthday)		Year	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		91 yrs.		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.			
WIDOWED <input checked="" type="checkbox"/>		March 4, 1876		Months Days Hours Min.		Months		Hours			
DIVORCED <input type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME		Corinth, W.Va.		U.S.A.			
14. MOTHER'S MAIDEN NAME		Nancy Jane Davis		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
NO		220-52-9841		Mrs. Tina James, Kitzmiller, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED?		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8 days 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19		Jan 1967, to Oct. 26, 1967, that (I) (we) last saw the deceased alive on Oct. 26, 1967, and that death occurred at 5:20 P.M. the causes and on the date stated above.									
22a. SIGNATURE		Ralph Calandrella		M.D.		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		Dr. Ralph Calandrella, M.D. Kitzmiller, Md. 21538		22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		Burial 10/29/67		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county)		(State)	
						I.O.O.F. Cemetery Blaine, W.Va.		Elk Garden, W.Va.			
24. FUNERAL DIRECTOR'S SIGNATURE		Amy Michel Sharpless, P.O. Kitzmiller, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					

21 v. 2

FOR STATE  
HEALTH DEPT



If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Ch of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

5917

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13922

1. PLACE OF DEATH a. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased resided, if institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Swanton			c. LENGTH OF STAY IN lb Years		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #1, Box # 39			d. STREET ADDRESS Route #1, Box #39		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First: ROSE Middle: MARY Last: KOLB			4. DATE OF DEATH Month: October Day: 16 Year: 1967		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH March 21, 1905		9. AGE (In years less birthday) 62 yrs		10. IF UNDER 1 YEAR Months: 0 Days: 0 Hours: 0 Min: 0	
11. DO USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Winder			12. COUNTRY USA		
13. FATHER'S NAME John J. Fitzpatrick			14. MOTHER'S MAIDEN NAME Rose Cunningham		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO 160-12-5231		
17. INFORMANT John Fitzpatrick, Swanton, Md.			Address (Brother)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis			INTERVAL BETWEEN DEATH AND DEATH Minutes		
DUE TO (b) Arteriosclerosis, generalized			Years		
DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Metastatic carcinoma					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above) held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i> M.D.					
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.					
22. DATE SIGNED 10-16-67					
Address (Street, city, town or county) Oakland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF October 16, 1967		23c. NAME OF CEMETERY OR CREMATORIUM St. Joseph Cath. Cem.	
23d. LOCATION (City or Town) East McKeesport, A. Pa.		(County)		(State)	
24. FUNERAL DIRECTOR John O. Durst		ADDRESS <i>John O. Durst</i>		25a. REC'D BY REGISTRAR	
Leightin-Durst Funeral Home, Oakland, Md.				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE OCT 17 1967					



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2b & c film #G123 10/11/1967

13923

## CERTIFICATE OF DEATH

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.Page 4 may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Garrett</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>5 hrs. 40 Min.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>		e. STREET ADDRESS <b>115 N. Main / Nikep</b>	
3. NAME OF DECEASED (Type or print) <b>Susan Elizabeth Lee</b>		4. DATE OF DEATH Month <b>October 10, 1967</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED WIDOWED <b>Divorced</b>		8. DATE OF BIRTH <b>11-4-87</b>	
9. AGE (In years last birthday) <b>80 yrs</b>		10. IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Romney, Wva.</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Isaac Bowman</b>		14. MOTHER'S MAIDEN NAME <b>Matilda Jane Dowman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Lester Lee</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) <i>Cerebral Vascular Accident</i> <i>Arteriosclerotic Cardiovascular Disease Unknown</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 8 1967</b> to <b>10-10-1967</b> , that (I) (we) last saw the deceased alive on <b>10-10-1967</b> , and that death occurred at <b>7:05 AM</b> from causes and on the date stated above		22b. DATE SIGNED <b>11 Oct 67</b>	
22a. SIGNATURE <i>Susan J. Leighton</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22b. PHYSICIAN'S NAME (Type) <b>Dr. H. Leighton</b>		22d. ADDRESS <b>Oakland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/13/1967</b>	
23c. NAME OF CEMETERY OR CREMATORIUM <b>Laurel Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Moscow, Md.</b>	
24. FUNERAL DIRECTOR <b>George Eichhorn</b>		25a. REGISTRATION NUMBER DATE <b>OCT 16 1967</b>	
ADDRESS <b>Lonaconing, Md.</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13924

CERTIFICATE OF DEATH

3919

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>10 days-10½ hrs.</b>		2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a. STATE <b>West Virginia</b>		b. COUNTY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF D (Type or print)		First <b>Freda</b>	Middle <b>Wildred</b>	Lost <b>Mason</b>	4. DATE OF DEATH <b>October 17, 1967</b>	Month <b>October</b>	Day <b>17</b>	Year <b>1967</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 7, 1900</b>	9. AGE (In years lost birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife-Postal Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>		11. BIRTHPLACE (County & State or foreign country) <b>Bayard, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>William</b>		14. MOTHER'S MAIDEN NAME <b>Parker</b>		15. INFORMANT <b>Margaret</b>		16. SOCIAL SECURITY NO. <b>236-20-9830</b>		Address <b>Richard Arnold Bayard, W. Va.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) DUE TO		(c) DUE TO		<i>Coronary Artery Disease</i> <i>subacute Thrombosis</i> <i>Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b> <b>5 m</b> <b>6 years</b>		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18b)		20d. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Bayard</b>	(County) <b>W. Va.</b>	(State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to Oct. 17, 1967, that (I) (we) last saw the deceased alive on <b>16 Oct 1967</b> , and that death occurred at <b>4:35 AM</b> from causes and on the date stated above										
22a. SIGNATURE <i>A. E. Mance</i>		22b. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <b>Dr. A. E. Mance</b>		22d. ADDRESS <b>Oakland, Maryland</b>		22e. DATE SIGNED <i>18 Oct 67</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/20/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Bayard Cemetery</b>		23d. LOCATION (City or Town) <b>Bayard</b>		(County) <b>W. Va.</b>		
25a. FUNERAL DIRECTOR <i>Gerald D. Minnich</i>		25b. ADDRESS <b>Oakland, Maryland</b>		25c. RECED BY REGISTRAR <b>OCT 30 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13925

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH <input checked="" type="checkbox"/> COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <input type="checkbox"/> STATE <b>Maryland</b> <input checked="" type="checkbox"/> COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>2 1/2 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cuppett-Weeks Nursing Home</b>		d. STREET ADDRESS <b>Friendsville</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>First LUCY</b>		4. DATE OF DEATH Month <b>October</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <input checked="" type="checkbox"/> Female		6. COLOR OR RACE <input checked="" type="checkbox"/> White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED		8. DATE OF BIRTH <b>Aug. 12, 1875</b>	
9. AGE (In years day/birthday) <b>92 yrs.</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Garrett Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Winfield S. Friend</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Walter Green, Arlington, Va.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <input checked="" type="checkbox"/> IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b></span> <b>4221</b> DUE TO <input checked="" type="checkbox"/> (b) <b>arteriosclerotic Cardiovascular Disease Unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <input type="checkbox"/> (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <b>Aug. 8, 1967</b> to <b>Oct. 8, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct. 6, 1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>9 October 67</b>	
22a. SIGNATURE <i>Herbert H. Leighton</i>		22b. ATTENDING M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M.D.</b>		22d. ADDRESS <b>Oakland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/10/67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Frostburg Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Frostburg, Maryland</b>	
24. FUNERAL DIRECTOR <i>Garrett</i>		25a. REC'D. BY REGISTRAR <b>OCT 11 1967</b>	
Durst Funeral Home, Frostburg, Maryland		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1  
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13926

**TO HOSPITAL** \_\_\_\_\_  
 death. Page 1 to be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE	
Garrett		MARYLAND b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN MD 2 yrs. 8 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. 1 Box 403		d. STREET ADDRESS Rt. 1 Box 403	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Day Year	
First Middle Last		Month Day Year	
Dora Matalia Sines		Oct. 1, 1967	
5. SEX		6. COLOR OR RACE	
Female		White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/>		Aug. 16, 1876	
DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) 91 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Hazelton, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jack Rhodeheaver		14. MOTHER'S MAIDEN NAME Verna Guthrie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> no		16. SOCIAL SECURITY NO. 217-54-6496	
17. INFORMANT Clayton Sines		Address see # 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) 4321 Cerebral Thrombosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior Sclerotic CV Disease		INTERVAL BETWEEN ONSET AND DEATH hrs 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from ... Jun 1963 to ... Oct 1, 1967, that (I) (we) last saw the deceased alive on ... Sept 21, 1967, and that death occurred at 8 A.M. from the causes and on the date stated above			
22a. SIGNATURE B. G. Grant, M.D.		22b. DATE SIGNED 10 Oct 61	
22c. PHYSICIAN'S NAME (Type) B. G. Grant, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/3/67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bray Cemetery ADDRESS Oakland, Maryland		23d. LOCATION (City, town or county) (State) Garrett Co. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Gerald D. Minnich		25a. REC'D BY REGISTRAR OCT 4 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												13927					
CERTIFICATE OF DEATH						13927											
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)														
a. COUNTY		a. STATE		b. COUNTY													
Garrett		Md.		Garrett													
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?					
Oakland, Md.			18 Months			McHenry						YES <input type="checkbox"/> NO <input type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)																	
Oak Rest Nursing Home																	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year			
Andrew Jackson Thomas								October 19		19		67					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.					
M		W		WIDOWED <input checked="" type="checkbox"/>		Divorced <input type="checkbox"/>		June 17, 1878 89 yrs.		Months		Days		Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?								
Retired Merchant			Grocery			Preston County, W. Va.			USA								
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME														
Alexander Thomas			Sarah Ann Fearer														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address								
No			213-18-0918			Charles Thomas, McHenry, Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>															hr		
4201 Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic CV disease</i>															yr.		
DUE TO (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															19. WAS AUTOPSY PERFORMED?		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
19																	
21. I certify that (I) (this hospital) attended the deceased from <i>Apr</i> , 1965, to <i>Oct</i> , 1967, that (I) (we) last saw the deceased alive on <i>12 Oct</i> 1967, and that death occurred at M, from the causes and on the date stated above.																	
22a. SIGNATURE <i>B.L. Grant M.D.</i>															22b. DATE SIGNED <i>10/20/67</i>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS <i>Oakland Md.</i>														

23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>10/21/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Sand Spring Cemetery Friendsville, Garrett, Md.</i>		23d. LOCATION (City, town or county) (State) <i>Friendsville, Garrett, Md.</i>	
24. FUNERAL DIRECTOR <i>Such Newman</i>		ADDRESS <i>Grantsville, Md.</i>		25a. REC'D BY REGISTRAR <i>OCT 26 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13923

CERTIFICATE OF DEATH

13925

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death.  
Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN b 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cuppett-Weeks Nursing Home			d. STREET ADDRESS Route #1		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			11-1		
3. NAME OF DECEASED (Type or print)	First MARY	Middle MARGARET	Last WHITE	4. DATE OF DEATH October	Month 8, 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1908	9. AGE (In years last birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Garrett Co., Maryland	
13. FATHER'S NAME Lewis White			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT			Address (Brother) Harry White, Rt #1, Deer Park, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure - Pulmonary Edema</u> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH 3 days</span> 414X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonic Heart Disease - Pleuritic</u> <span style="float: right;">30 years</span> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/24</u> , 19 <u>52</u> , to <u>10/5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/6</u> , 19 <u>67</u> , and that death occurred at <u>9:35</u> A.M. from <u>Mouses</u> and on the date stated above.		22a. SIGNATURE <u>Herbert H. Leighton, M.D.</u>			
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9 Oct 67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/10/67		23c. NAME OF CEMETERY OR CREMATORIAL White Church Cemetery	
24. FUNERAL DIRECTOR Leighton-Durst Funeral Home		ADDRESS <u>John O. Durst</u>		23d. LOCATION (City or Town) Near Oakland, Md.	
25a. REC'D BY REGISTRAR OCT 11 1967		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

